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Improving Spiritual Care in Hospitals in the Netherlands: Experiences of Health Care Chaplains Involved in an Action-Research Study

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Abstract

Health care chaplains participated in an action research study that explored an implementation strategy for multidisciplinary guidelines for spiritual care. The intervention was a spiritual care training session for multidisciplinary teams in the context of palliative care in hospital departments with patients in curative and palliative. Data were collected in semi-structured interviews with the chaplains who acted as co-researchers and trainers before and after the intervention. Results based on nine pre-intervention and eleven post-intervention interviews are presented. Before the intervention, chaplains reported that conducting research would create opportunities for improving spiritual care and promote new relationships with physicians, nurses and managers. In the post-intervention interviews, the characteristics of the training, its effects, and its critical success factors were identified. Action research is a feasible method to explore the implementation of spiritual care guidelines. Training can be effective, and healthcare chaplains can develop multidisciplinary competencies in carrying out research projects.

Keywords: evidence-based chaplaincy, education, multidisciplinary team, spiritual care, palliative care.

Improving Spiritual Care in Hospitals in the Netherlands: Experiences of Health Care Chaplains Involved in an Action Research Study.

In 2014, George F. Handzo and others issued a call for action to chaplains worldwide to develop an outcome-oriented approach to chaplaincy care (Handzo, Cobb, Holmes, Kelly, & Sinclair, 2014). Because attention to spiritual issues is an intrinsic part of palliative care (PC), it is no coincidence that three of the four early examples that they highlighted fell within the context of programs for developing PC. The program in Scotland is the only example of a broader, community-directed approach based on the concept of wellbeing (Bunniss, Mowat, & Snowden, 2013). The World Health Organization's definition of PC (World Health Organization, 2017), which involves formulating a bio-psycho-social-spiritual model of care, is likely to have opened a new door for chaplains to reformulate the specific characteristics of their profession. It offers opportunities to articulate the contributions that chaplaincy can make to the quality of patient care, the multidisciplinary team, and the culture and organization of the health care institutions where chaplains work. In the literature, the integration of spirituality and the development of a more person-centered, compassionate care within health care is by nature a multidisciplinary discourse, with contributions from areas such as nursing (McSherry & Ross, 2012), medicine (Puchalski, 2006; Sulmasy, 2006), and social work (Holloway & Moss, 2010).

Although it is not easy for chaplains to articulate and measure the value of their results in systems that are still dominated by the biopsychosocial model (Engel, 1977), the need to join this multidisciplinary discourse is felt widely. An important development in these discourses have been the dialogues aimed at consensus on defining and integrating spirituality in modern health care, among which the Consensus Report from the United States (Puchalski et al., 2009) is an inspiring example.

In the Netherlands, PC has always seemed to be a natural starting point for the development of spiritual care (SC) and its integration with modern health care. Although this should not to be limited to PC, as explicitly illustrated in the *Oxford textbook on spirituality in healthcare* (Cobb, Puchalski, & Rumbold, 2012), chaplains saw the opportunity to integrate the spiritual dimension into the national PC program. The publication of a consensus-based multidisciplinary guideline on spiritual care (hereafter: the SC guideline), one year after the publication of the US Consensus Report, was a first step (Leget et al., 2010). This SC guideline was published in the national guidelines for the practice of multidisciplinary PC (De Graeff et al., 2010). English, German and Spanish translations are available online (Taskforce Spiritual Care & European Association for Palliative Care, 2016).

One of the essential characteristics of the Dutch PC program is that PC is part of the mainstream healthcare provided by general care providers (Brinkman & Gootjes, 2009). Therefore, the SC guideline has been developed primarily for physicians and nurses who are not specialists in PC.

After its publication, the SC guideline was positively received in the field, but there was no strategy for its implementation (van de Geer & Leget, 2012). Because the guideline acknowledges the position of healthcare chaplains as SC specialists who are available in most hospitals and nursing homes (Vandenhoeck, 2013), it created an opportunity for chaplains to explore what they could contribute to a national strategy for the implementation of this guideline.

Aims

The aim of our study was to explore an implementation strategy for the SC guideline by training healthcare professionals in SC, with chaplains in the role of co-researchers and teachers of the pilot training. A multicenter trial in ten hospitals was planned using a mixed-method action-research approach.

The research questions were as follows: What is the effect of this training on a. the knowledge of chaplains about primary healthcare professionals' needs concerning the application of the SC guidelines and b. the knowledge of healthcare chaplains about the possibilities for integration and implementation of SC in the work processes of the multidisciplinary team? Is it possible to train physicians and nurses effectively within reasonable time limits?

The intervention in this exploratory practical trial was a SC pilot training for physicians and nurses that was planned in wards where patients are treated in curative and palliative trajectories (van de Geer et al., 2016a). The manner in which spirituality is integrated system-wide in the Dutch national PC program was reported in 2012 (van de Geer & Leget, 2012). The effects of the pilot training on the quality of care in patient-reported outcomes have been reported in a medical journal (van de Geer et al., 2016b). The effects on barriers to SC and SC competences for health care professionals will be published in the American Journal of Hospice and Palliative Medicine.

In this article, the participating chaplains' learning processes, based on nine pre-intervention and eleven post-intervention interviews, are reported.

Methods

Participants

In August 2013, the chaplaincy teams of all 27 members of the Association of Tertiary Medical Teaching Hospitals (*Stichting Topklinische Ziekenhuizen, STZ*) were invited to participate in the study. These hospitals are not university clinics but larger general hospitals for standard and complex specialized care, and they play an important role in the teaching of medical and nursing disciplines and in research and innovation in Dutch health care. Interested chaplaincy teams were invited for an Expert Meeting in November 2013, together with 20 national and international experts on PC and SC. In this meeting, the

requirements for the intervention, the pilot training ‘spiritual care for multidisciplinary teams’ (referred to hereafter as the training), and the action research approach were discussed and determined.

This mixed-method study was designed and conducted in accordance with the WHO Good Clinical Practice Guidelines. Ethical approval was granted by the medical ethical committee in Leeuwarden, Netherlands on July 4, 2013 (nWMO22). This study was registered at the Dutch Trial Register: NTR4559.

The hospital inclusion criteria were as follows (van de Geer et al., 2016): membership in the STZ, active involvement in developing PC, and implementation of a PC quality improvement program.

The chaplaincy team inclusion criteria were as follows: active involvement in the PC improvement program in the hospital, feeling responsible for the way in which SC is developed in that program, having at least one member of the team specialized in SC in PC (mandatory specialized training program) (Leerhuizen Palliatieve zorg, 2016), and potential trainers who have their own learning style assessed via the Kolb Learning Style Inventory 3.1. (Kolb & Kolb, 2005).

Our target was to include ten hospitals. Eleven chaplaincy teams showed interest in participating in the trial, but two of these did not meet the inclusion criteria, and one withdrew because of methodological objections. Ultimately, the chaplaincy teams from eight hospitals received approval from the medical-ethical or local research committees and hospital management to participate in the study (see Figure 1).

[Figure 1. Flow diagram]

[Table 1. Co-Researchers/Trainers, Pilots, Hospitals]

Procedure

Key concepts of action research as defined by Koshy, Koshy, and Waterman are *a better understanding, participation, improvement, reform, problem finding, problem solving, a step-by-step process, modification* and *theory building*." (Koshy, Koshy, & Waterman, 2011). With this approach, the position of the chaplains as co-researchers can be described as practitioners improving their practice in a process of change.

The cooperation with the investigator can be described as a continuous learning process for both parties, sharing newly generated knowledge with those who could benefit from it. Action research is context bound, which means that variation in the intervention is expected because local adjustments of the study protocol are accepted as a problem-solving strategy and could generate new knowledge. Stimulating professionals to integrate SC with PC in their working process as a multidisciplinary team can only be successful if it builds on location-specific resources that are connected to the unique culture of each participating hospital or department. Therefore, adjusting the training to local circumstances is not considered a deviation from the study protocol and did not lead to hospitals being excluded from the study.

The participating chaplains were responsible for conducting the study according to the protocol (van de Geer et al., 2016a): planning and carrying out the training in the intervention wards, including the participating health care professionals in the study of the effects on barriers and competencies for SC, selecting control wards, and -- in cooperation with the local PC consultation teams -- organizing the process of selecting palliative patients for the study of the effects on the quality of care.

In their roles as co-researchers and trainers in SC, the chaplains were interviewed twice, one month before the pilot training started and one month after the training ended, to collect practical experiences and newly developed practice-based knowledge.

The chaplains were familiar with the interviewer, a male senior healthcare chaplain, as a trainer in and ambassador for multidisciplinary SC.

All respondents were experienced chaplains and educators. Most chaplains had experience with teaching nurses, and only two had experience with teaching physicians. None of the chaplains who were interviewed had any previous experience in research.

The participants received the questions before the semi-structured interviews were carried out on site in the hospitals. All participating chaplains were interviewed, and no non-participants were present. Twelve chaplains were interviewed, six of whom worked together as colleagues in the study; these pairs participated in a paired interview. In the interviews with this latter category, no differences were observed between the answers, so these pairs were considered one respondent (see Table 1).

During the project, 20 interviews were conducted: nine interviews at eight sites before the training (at one site, two separate pilots were conducted with different chaplains as the trainers) between December 9, 2013, and September 25, 2014; one on-site interview between a first and second training; and ten interviews at eight sites (at two sites two pilots were carried out) after the training between September 29, 2014, and March 18, 2015 (duration 50-85”, average 55”).

All interviews were audio recorded, field notes were made during the interviews, and transcripts were checked and corrected by the researcher if necessary. Transcripts were not returned to the participants for comment.

Analysis

For the pre-intervention interviews, the first concept-coding tree was based on the questions sent to the chaplains to prepare for the interview. Transcripts were coded in ATLAS.ti Version 7.1.4. The interviews were coded by two researchers (JvdG, SL), adding new codes and sub-codes to the tree. They discussed their codes until consensus was reached

on coding policy and coding tree, and then they discussed the result with a senior researcher (THZ). One of the researchers (SL) performed a problem-driven content analysis.

For the post-intervention interviews, the initial coding tree was based on the final tree of the pre-intervention. Transcripts of the post-intervention interviews were coded in ATLAS.ti Version 7.5.10. Again, two researchers (AV, JvdG) coded the interviews, adding new codes and sub-codes to the tree. They discussed their codes until consensus was found on the codes and coding tree. Problem-driven content analysis was performed by JvdG. The results of this analysis were also discussed with the senior researcher. An example of a qualitative theme and supporting quotations is presented in Table 3 Coding Example Post-intervention Interviews.

The authors considered data saturation to be reached within the context of this small study because all participating chaplains were interviewed in two rounds using a semi-structured format that enabled the chaplains to answer the research questions. The research team was confident that they had sufficient data and considered that the presented themes reflected the chaplains' experiences.

Pre-Intervention Interview Results

The topics for the semi-structured interviews included motivation for participation, PC in the hospital, chaplains' participation in PC, experiences with teaching SC, characteristics of the participating wards, planning the training, use of diagnostic tools for SC, new experiences or knowledge based on participation in the study, and further plans for developing SC.

First, some general findings are summarized, and then the three themes that are most relevant to the exploration of an implementation strategy for SC are addressed in more detail: context of PC in the hospitals, chaplains' views on developing SC, and new knowledge based on participation in the study.

General Impression of Pre-Intervention Interviews

As an impeding factor for the development of SC, the chaplains mentioned the combination among primary health care professionals of the obvious curative attitude throughout the hospital on the one hand and a lack of knowledge about PC on the other. This often impedes the recognition of the shift to the palliative phase in the treatment of patients or even the start of the dying phase. At the same time, the chaplains observed willingness to improve end-of life-care and the recognition of healthcare professionals' need for PC training, which they considered supporting factors for developing PC and SC. In general, the chaplains reported a positive attitude towards the project among the nurses. Building relationships with physicians was described as more difficult, but when forced by the protocol to try to include physicians in the training, the chaplains usually encountered an appreciative attitude toward the development of SC and health care chaplaincy; in only one case was the chaplain in question confronted with an indifferent or even degrading attitude.

Context of Palliative Care in Dutch Hospitals at the Time of the Study

For half of the hospital sites, the chaplains reported the cooperation with the PC teams to be stimulating. Although one of the inclusion criteria for hospitals was the presence of a quality-improvement program for PC or a PC consultation team, a large variation in staffing, structure, and financial set-ups was observed. There was no standard for PC in hospitals at the time. At hospital 5 the PC team was disbanded after the start of the study and had not been reinstated at the end of the study.

In none of the hospitals or PC teams was any diagnostic tool for spiritual screening used. Three chaplains report the use of the distress thermometer (de Haes, Aaronson, & Hoekstra-Weebers, 2010) by oncology nurses, a tool recommended in national guidelines for oncology care for the screening of somatic, psycho-social and spiritual distress. However,

this tool is not approved by the Dutch health care chaplains' organization VGVZ (*Vereniging van Geestelijk VerZorgers*).

Chaplains' Motivations and Perspectives Concerning the Development of Spiritual Care

All participating chaplains declared themselves to be strongly aware of the need to develop a more research-based chaplaincy. Their motivation for participating in the study was connected to a desire to improve the quality and profile of the chaplaincy and the opportunities that our study could provide for developing SC as a multidisciplinary dimension.

> Chpl. 4.4: *Will we really be able to express what we mean by spiritual care? I myself often have the feeling that I am too vague, but at the same time, people do sense what you mean. That's what I find so difficult sometimes.*

Respondents mentioned a tension between their language as chaplains and the common medical language between primary health care professionals. They formulated the need for a multidisciplinary common language that is complementary to the medical discourse and includes symbolic or metaphorical language.

> Chpl. 5: *… therefore, you develop a common language. Now, we have only a medical language that we can speak, but we lack a language for the symbolic reality. And I do hope that the intervention brings some awareness of that.*

All respondents shared the conviction that SC training is a challenge and an opportunity for the chaplaincy to be more integrated in the multidisciplinary team. Some chaplains pointed to the need to modernize chaplaincy, a process that they characterized as a shift from chaplaincy as a domain to chaplaincy as a specific expertise.

> Chpl. 3: *So it is not our domain, forbidden to others, but an expertise you want to communicate.*

The chaplains were aware of the fact that developing this language is not possible as a one-way communication; it needs to occur in dialogue.

> Chpl. 4.4: *In this kind of care, it is about a way of being, an attitude. You can only do something about that by talking about it together and, say, exchanging views referring to that.*

> Chpl. 3: *I think that the chaplain can also learn from the professionals what they mean by spiritual care. Maybe both parties will have to adjust the images they have of spiritual care.*

New Experiences or Knowledge Based on Participation in the Study

The procedure for obtaining permission for the research project within the hospital was new for all chaplains, but it was considered a fruitful learning process that also improved their profile:

> Chpl. 6: *You are taken more seriously when you are doing a research project.*

It provided chaplains with both new knowledge about the organizational structures in their hospital and new experiences in conducting a quality-improvement project in an action-research approach. It created new relations with physicians and managers.

> Chpl. 7: *I enjoyed it very much at my lung ward, how, step by step, I was able to get that manager to go along. And how fruitful now* [before the training] *it already is. He has asked me to initiate a discussion about 'How do we handle troublesome patients?' He would never have done that if we had not embarked on this study. So now he already has a fully new perspective on me and my work.*

Post-Intervention Interview Results

The topics for the semi-structured post-intervention interviews included preparation of the intervention and data collection, the baseline situation in intervention wards, characteristics of the training, critical success factors, health care professionals' preferences

for specific SC diagnostic screening tools or models, chaplains' new knowledge and skills, and training effects. After providing a general impression of the characteristics of the training as performed by the chaplains, the most relevant themes for the implementation of SC are described: critical success factors, chaplains' new knowledge and skills, and effects of the training.

General Impression of Post-Intervention Interviews

The overall impression from the interviews is that the chaplains experienced the research project as a demanding, time-consuming, but fruitful and positive process. For all chaplains, the mandatory specialized training in SC was vital to their preparation for the training, and for most chaplains, the additional training on educating professionals (learning styles, teaching methods) and the exchange of experiences in three group meetings were also vital.

Three chaplains expressed frustration due to external factors: in hospital 1, no pilot was performed because of an understaffed PC team; in hospital 7, the pilot had not been developed fully according to protocol because of the integration of the pilot in a larger PC training program; and one chaplain reported suboptimal performance during the pilot because of sickness during preparation.

The overall preparation was described as a process, and seven of the nine chaplains reported that, in their view, the objectives of making health care professionals aware of the spiritual dimension of their work and enhancing their competencies were achieved (in particular among nurses).

Although chaplains who trained physicians (either together with nurses or in monodisciplinary groups) expressed their doubts about whether their training had met the physicians' training needs. They said that they had been able to build bridges between nurses and physicians to develop forms of multidisciplinary SC.

Three chaplains said they planned to use one of the diagnostic SC tools on which they had trained as a format for reporting their visits in patients' medical records. The other chaplains did not formulate any specific implementation strategy to structure a working process for SC.

Four of the chaplains were planning to offer a structural training on SC in cooperation with education departments, PC consultation teams, or third parties outside the hospitals.

The SC training intervention was performed nine times in seven hospitals, between February 2014 and February 2015. The wards that appeared to be most open to SC improvement were the lung and oncology wards. The characteristics of the training varied locally. For a table detailing all requirements of the training, we refer the readers to our study protocol (van de Geer et al., 2016a).

[Table 2. Pilot Training Spiritual Care]

The conclusion from the experiences and reports of this group of chaplains was that having only one training session was less than effective. Two sessions, preferably of 90 minutes each, made it possible to start in the first lesson with the basic theory illustrated by the case descriptions prepared earlier. The time between the sessions was used to stimulate participants to provide detailed personal case descriptions, applying the theory learned in the first session. With this setup, these case descriptions were available in the second session to illustrate and practice the models and diagnostic tools trained. These second sessions appeared to be more practical, resulting in enhanced commitment and better evaluation rates.

The chaplains interviewed reported a preference for small groups, but for implementation in larger wards, a training session in larger groups, including interactive training methods in small groups, proved to be equally effective.

Whenever, for practical reasons, the chaplains opted for monodisciplinary training of physicians and nurses, they found this to be more practical, be easier to organize, and have

the advantage that the training could be adjusted to the specific training needs and reflective competencies of each discipline. In contrast, chaplains who trained multidisciplinary groups reported that in these groups participation and contributions by physicians enhanced the quality of the training because this deepened the reflections on case descriptions, eliminated mutual stereotypes between physicians and nurses, created a collective commitment to the development of integrated working processes for SC in the ward, and legitimized nurses to engage in SC.

> Chpl.5: *I was greatly helped here by an internist, who put this into words clearly... She said 'This is a different question from 'How are you today?' Then, patients start telling you... about their temperature... Asking about meaning is a different question.' Shortly before that, some nurses had walked the rounds with the specialists for a day and had been very surprised to find that these aspects did come up. …The idea that 'the doctors do not see these things' has been turned completely upside down. But it does not always register with the other party. Of course, it's not the language they speak with each other*
>
> *Chpl.2: And nurses... they do have much more of an antenna for that sort of thing. But they also feel a bit uncertain about whether the doctors are OK with it. 'If I take the time to talk to a patient, sit down with them -- do they understand?*

At the first observation, Table 2 seems to show that in most cases all three themes required by the protocol (sensitizing, reflection on one's own spirituality and confrontation with end-of-life care, and integration in professional practice) were included and that in most cases, all four SC competencies (recognizing, attuning and referring, self-reflectiveness, open attitude towards patients' spirituality) were trained. However, most chaplains explained that a lack of time forced them to merely mention the relevance of reflection on one's own spirituality and experiences in confrontation with end-of-life care. The main and most

successful topics in the training were sensitization to and recognition of the spiritual dimension by using a diagnostic tool and symbolic listening. As Chaplain 3 mentioned,

> *That was an eye-opener. If a patient says: 'Well, then, I may as well get rid of my caravan', you can interpret that as 'I am at the end of my life, I have to let go of the nice things in my life, I will die very soon.' But you can also hear 'that caravan has been an important part of someone's life; it has been a source of joy.' And then you listen differently. ... Like, 'hey, if someone says something like that, what has been the function of that caravan... What do you hear then?'*

When asked which model the physicians and nurses preferred, six of the nine chaplains identified the questions of the Mount Vernon Cancer Network (Mount Vernon, 2007)assessment tool as the most practical and compatible with the medical model (see Table 3.). The three questions in this tool are 'how do you make sense of what is happening to you', 'what sources of strength do you look to when life is difficult', and 'would you find it helpful to talk to someone who could help you explore the issues of spirituality/faith?'. In most training sessions, this screening tool for spiritual needs is combined with symbolic listening (Weiher, 2011). The latter is a method for interpreting patients' daily conversations or answers to the screening questions and for guiding health care professionals' reactions. The third model available for the pilot training, Ars Moriendi (Leget, 2007), was mentioned only occasionally and was used by only two chaplains.

Three chaplains mentioned unexpected chances to secure the results of the training in occasional or structural team meetings and in moral deliberations. Coaching on the job appears to be the most effective, but demanding, means to secure the results of a training in SC. Only one chaplain was able to adopt it as a method whenever she was referred to patients in the 'training' ward. She said,

> Chpl.7: *I do that with all referrals I now get for that ward, I always … make a point of saying 'look, this is what we talked about [in the training]. …. look what I have reported, there you can read what I do and what I recommend'. I now consciously use words from the training, so that they see 'this is what you already did and this is what I'm doing now' and 'this is the way you can take this up'. … And then they want to hear back from you after you've been. So, I do that much more often now. I do not always manage in person, but then I tell them where to find my report. ... So, this is all coaching on the job.*

[Table 3. Coding Example Post-intervention Interviews]

Critical Success Factors

For seven chaplains, without the study protocol or a clear mandate a project-based implementation of the SC guidelines would not have been a matter of course. As Chaplain 5 stated,

> *... before, I never felt obliged to implement the guideline. Odd, really.…. I did not know where to start. I use the guideline occasionally in a lesson, if I'm allowed to give one. But in a hospital... where everything is in constant flux ... I would not have introduced a guideline of my own accord. I would have left it. Just because I would have no idea how and where to introduce it in this organization.*

Other critical success factors with regard to the chaplains' attitude were authenticity, visibility, and personal commitment to the team members on the ward. The research project and the training offered opportunities to break down the traditional stereotypes of chaplaincy that are most commonly found among nurses and physicians.

A critical success factor for the participating wards was determined to be their ownership of the project: active commitment on the part of management and physicians and the sense of bottom-up commitment on the part of nurses.

According to Chaplain 7, it is important to stress that SC is not an additional task but is inherent in health care professionals' practice and deeply connected to their original, deeper motivation for choosing this profession.

> Chpl.7:... *I think everyone has in fact been doing this for a long time, and I should not be selling this training as something entirely new, but rather as I'm offering you tools and empowerment to make you more aware of what you are doing and get more out of it. Also, I thought it was a real find to be able to link it to, what I think was their original motivation for choosing health care as a profession , ... this would help to rediscover the human being behind the diagnosis and the patient. I found this a great help to win people over, eyes started to shine.*

Health Care Chaplains' New Knowledge and Skills

Action research proved to be an effective method to gather practical knowledge for developing and performing quality improvement or research projects. In our project, knowledge about learning styles and educational theory for training professionals was gathered or renewed, and chaplains' training skills were enhanced. In particular, they discovered the value of learning by doing and the fact that chaplains are more theory-minded than other healthcare professionals.

The chaplains reported an improved understanding of the differences in professional practice between physicians and nurses and of the barriers to SC within both disciplines. They also discovered that the varying levels of reflective competencies within teams were independent of working experience.

> Chpl.5: *What also struck me is that a physician sometimes has more time for a palliative patient in a short meeting in his office than a nurse rushing from one patient to the next one.*

The majority of the chaplains stated that the process reaffirmed their self-consciousness as professionals with a valuable contribution to health care:

Chpl.4.10: *True, I found that we do have a good story and that patients are actually waiting for it. More than one doctor confirmed this to me.*

Effects of the Training

Although most chaplains are positive about the improvement in trainees' competencies, it is difficult for them to measure the effect on the quality of care as perceived by patients. Three chaplains thought that they had improved the quality of their profile and visibility on their wards, and they were able to indirectly deduce improved patient care based on the quality of the referrals.

For three other chaplains, the effect on patient care was outside their field of vision. The remaining three chaplains were skeptical or negative about the effect on patient care.

Six chaplains reported improved and intensified relations with physicians:

Chpl.2: *Less than a week after the training, two doctors came to me, one in the bike shed and one in the corridor, and said 'that was an excellent training, it really affected me, it did something'. Mind you, these were specialists, not just junior doctors. You can't tell by looking at them, but something has changed, something is happening. I now report more in the doctors' notes than I used to, I used to do that mainly in the nursing file... I now find it easier to drop in at a specialist's office and say 'Patient such and such has this or that problem.' So, for me, the barrier to contact a specialist has again become a bit lower.*

Discussion

Our research questions were as follows: What is the effect of this training on a. actionable knowledge of chaplains about primary healthcare professionals' needs concerning the application of the SC guideline and b. knowledge for chaplains concerning the

possibilities for integration and implementation of SC in the working processes of the multidisciplinary team? Is it possible to train physicians and nurses effectively within reasonable time limits?

One conclusion is that according to the chaplains, the exploration of an implementation strategy for the SC guideline by training healthcare professionals in SC, with chaplains in the role of co-researchers and teachers, was a fruitful endeavor. It is possible to train physicians and nurse effectively (Van De Geer, 2016). Guidelines are a solid base for training health care professionals, and multidisciplinary guidelines stimulate cooperation between disciplines. Implementation of guidelines is not an obvious activity for chaplains, but it is a well-tested method for improving patient care (Grol & Wensing, 2015).

This study indicates that chaplains can play a vital role in implementing a consensus-based guideline for SC. By exploring training methods in an action-research design, the chaplains developed a more systematic approach, and they contributed to research-based answers to the needs of their colleagues in the multidisciplinary team.

The study has several strengths. First, it contributes to all five research priorities identified by Selman and colleagues in a worldwide survey among health care professionals: understanding of SC (who/what/where), staff education, understanding of spiritual needs and distress, SC for nonreligious people and people of different faiths, and conceptualizations and definitions of spirituality/the spiritual dimension (Selman, Young, Vermandere, Stirling, & Leget, 2014).

Second, this project meets the objectives of action research (Koshy et al., 2011). Performing the study according to the protocols in the local hospitals was a step-by-step process of modification and problem solving. Health care professionals have been empowered, including chaplains, nurses and physicians. Additionally, the study shows

reports of improved understanding among chaplains, nurses, and physicians, enhanced participation in performing multidisciplinary SC, and indications of improved patient care.

In addition, this publication hopes to contribute to the theory building concerning chaplaincy and an evidence-based practice of chaplaincy (Handzo et al., 2014).

Third, the project resulted in enhanced visibility and credibility of chaplaincy and improved SC in PC. In the pre-intervention interviews, it was observed that the fact that the study was based on a national guideline actually enabled the local chaplains to perform the demanding but fruitful activities in the project. Their performance also enhanced the profile of chaplaincy as a specialized, research-based health care profession. Working as a group in a multicenter trial, including eight of the 27 non-university training hospitals in the Netherlands, enhanced the impact of the project. It created national visibility, was awarded twice, and has already resulted in input for a project to improve SC within the national PC program.

On the basis of our findings, it is considered vital for chaplains to participate in developing multidisciplinary standards and guidelines and to develop a more outcome-oriented chaplaincy.

Finally, the multidisciplinary approach to SC training proved fruitful for the communication among chaplains, nurses, and physicians. Training SC enabled the chaplains to bridge the language gaps with and among nurses and physicians. Although monodisciplinary training has practical advantages, chaplains that performed training in multidisciplinary groups reported that the quality of the training was improved, cooperation was stimulated, and mutual stereotypes between nurses and physicians were eliminated.

The effect of the training on the quality of patient care could not be valued directly from the trainers' perspective.

Although the study protocol was limited to PC in hospitals, the chaplains' group agreed that this training needs to be developed further, and it is transferable to nursing homes, hospice, and home care, as well as to forms of acute and chronic care.

Two methodological aspects can be considered the main strengths of our study. First, it is not a one-site study but rather a multicenter trial, which indicates that the method is applicable in different contexts. Second, the use of mixed methods, which yielded quantitative results confirming the qualitative self-assessment of the chaplains or putting it into perspective.

A limitation of the explorative character of this study is that our results are indicative, and generate rather than confirm hypotheses. Additionally, the sample of chaplains is subject to selection bias. The inclusion procedure selected those chaplaincy teams that were willing to work on the implementation of the SC guideline, expecting it to create opportunities to improve patient care and chaplains' professional profiles. Therefore, this group of chaplains probably represents a group of pioneers.

The conclusion of this study is that chaplain-led, multidisciplinary spiritual care training is a feasible method for implementing the SC methods as described in the multidisciplinary guideline in hospitals. Positive effects such as lowering barriers to spiritual care, increasing health care professionals' competences, and increasing health care chaplains' profile are possible. However, several factors should be considered if the effectiveness of such a training is to be increased.

Input by physicians, or performing the training in tandem with a physician, could also benefit training and its relevance for physicians and nurses.

Implementing spiritual care guidelines is a new important part of a health care chaplain's profile.

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Table 1 Sample description co-researchers/trainers, pilots, hospitals

Chaplain	Gender / Age	Work experience as (years)		Denomination [a]	Pilot	Ward	Hospital / Beds (n)
		chaplain	trainer				
Ch. 1	M >50	> 10	> 10	Prot.	P. 1[b]	-	H. 1/643
Ch. 2	M >55	> 25	> 20	RC	P. 2	Lung	H. 2/883
(duo)	M >60	> 15	> 20	RC			
Ch. 3	M >60	> 15	> 20	RC	P. 3	Lung	H. 3/623
Ch. 4.3[c]	F >50	> 15	> 25	RC	P. 4[c]	Lung	H. 4/600
Ch. 4.10	M >55	> 5	> 30	Prot.	P. 10	Oncology	
Ch. 5	F >60	> 20	> 20	Prot.	P. 5	Oncology	H. 3/623
Ch. 6	F >50	> 20	> 10	Prot.	P. 6	Internal /	H. 5/148 (848)[c]
(duo)	F >45	> 10	> 5	Prot.		Oncology	
Ch. 7	F >45	> 5	> 20	Prot.	P. 7	Lung	H. 6/468
Ch. 8	M >50	> 15	> 15	Prot.	P. 8	PC consultants + ambassadors	H. 7/260 (925)[c]
Ch. 9	M >55	> 5	> 10	RC	P. 9	Renal	H. 8/850

[a] Prot. = Protestant, RC = Roman Catholic;

[b] pilot not performed, chaplaincy and palliative care team became understaffed after the start of the project

[c] the first training and the and post interview were performed as a duo, referred to as Ch.4.3, the second training and post interview is performed by the male chaplain, referred to as Ch.4.10;

[d] number of beds at site which is part of one multisite hospital organisation, total number of beds is presented in italics;

Table 2. Pilot Training Spiritual Care

Pilot N = 9	Ward/ # scheduled participants	Multidisciplinary/ monodisciplinary training	# Lessons / total minutes	# Groups/ Group size	Themes[a]	Competencies Trained [b]	Models trained[c]	Use of participant's CD / CJ[d]
P. 1	-	-	-	-		-	-	-
P. 2*	Lung/63	Multi. Mono.: nurses	1/60' 1/60'	4/15-20 4/10-12	1.2.3. 1.2.3.	1.2.3.4. 1.2.3.	1.2.3. 2.	-/- CD/-
P. 3	Lung/46	Multi.	1/150'	4/7-12	1.2.3.	1.2.4.	1.2.	-/-
P. 4	Lung/35	Multi.**	2/180'	3/8-12	1.3.	1.2.4.	1.2.	CD/-
P. 5	Oncology/91	Multi.	2/180'	5/16-25	1.2.3.	1.2.3.4.	1.2.3.	CD/-
P. 6	Internal/46	Mono.: nurses	2/120'	4/3-12	1.3.	1.2.3.4	2.3.	CD/-
P. 7	Lung/4912	Mono.: nurses Mono.: physicians	2/90-120' 2/50'	5/7-9 1/8-12	1.2.3. 1.2.3.	1.2.3.4. 1.2.3.4.	1.2. 1.2.	CD/CJ CD/-
P. 8	Various/16	Multi.	/45'	1/15	1.2.3.	1.3.	1.2.	-/-
P. 9	Renal/13	Mono.: nurses	2/120-240'	2/10-13	1.2.3.	1.3.4.	1.2.3.	-/-
P. 10	Oncology/195	Mono.: nurses Mono.: physicians	2/180' 2/60'	1/17-20 1/3-5	1.3. 1.2.3.	1.2.3.4. 1.2.3.4.	1.2. 1.2.	CD/- CD/-

* = training started as multidisciplinary during 60', then continued for 60' as monodisciplinary for nurses;

** = 1 physician;

[a] 1 = sensitizing, 2 = reflecting on participant's own spirituality and confrontation with end-of-life care, 3 = integrating into professional practice;

[b] 1 = recognizing, 2 = tuning and referring, 3 = self-reflectiveness, 4 = open attitude towards patients' spirituality;

[c] 1 = MVCN assessment tool, 2 = symbolic listening Weiher, 3 = Ars Moriendi Leget;

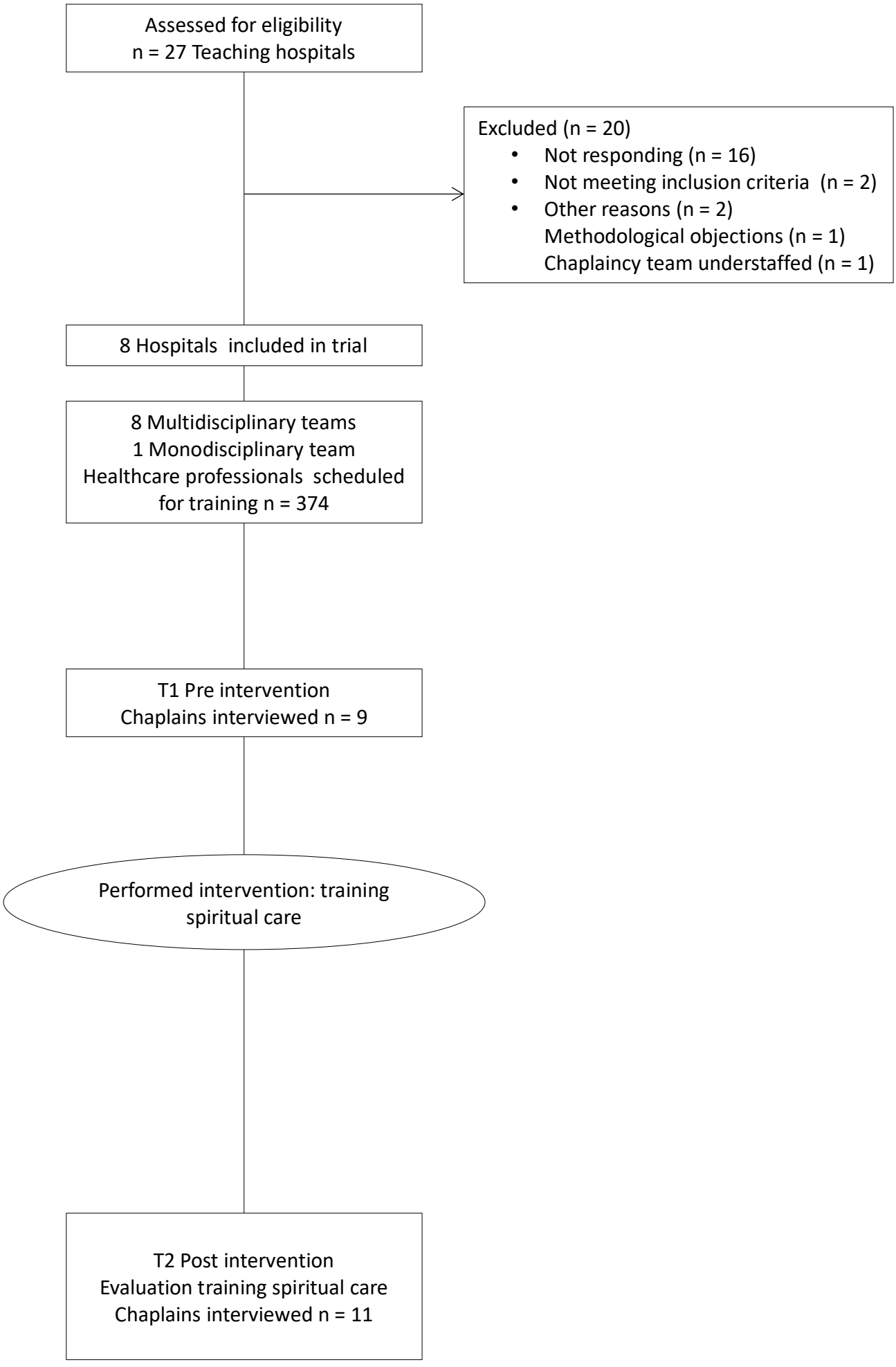
[d] Use of participant's CD / CJ = Case Descriptions (CD) / Coaching on Job (CJ).

Table 3. Coding Example Post-intervention Interviews

Chaplains' Perspective on Health Care Professionals' Preferences for Spiritual Care Diagnostic Tools

Family Code: 03 **Actual Characteristics of Intervention/Training** Codes:		**Code 3.7: Spiritual Care Tools Actually Trained** 9 out of 17 quotes
03.1	Multidisciplinary vs.	Chpl.2: And while we practised listening in layers, in the second half, the question 'how is it for you yourself' also became very prominent.
03.2	Monodisciplinary	
03.3	Spiritual Care Competences	
03.3.a	Actually Trained [Participants'] Preparation via Project Website	Chpl.3: Yes, I raised those three Mount Vernon-screening questions, and gave examples. Those are clear questions. I found that I could explain each example using Weiher; I know that would not have been as easy with Carlo's model. Something I also stressed is focusing on sources of strength rather than problems.
03.4	[Participants'] Preparation via Answering Baseline	
03.5	Questionnaire about their	
03.6	Spirituality	
03.7	Numbers of Sessions, Total	
03.8	Numbers of Minutes (per	Chpl. 4.4: I kept things very basic for the nurses and limited myself to those three questions: what are you worried about, who would you like to have with you, from what did you derive strength before?
03.9	Participant)	
03.10	Group Size, Total Numbers of	
03.11	Sessions and Participants	
03.12	Structure and Composition of Lessons	Chpl.4.10: Certainly, I did discuss the three questions, but we also always referred to the four layers in the training.
	Spiritual Care Tools Actually Trained	Chpl.5: Mount Vernon, listening in layers, but Carlo Leget as well. But only in the second lesson.
	Practical Assignment, Case Description	Chpl.6: The first lesson we practised layers, and wrote various questions that could be asked on the blackboard. That went quite well, so that in the second lesson we could refer back to that topic, like, last time we talked about listening in layers, this time we will do a bit of Ars Moriendi.
	Chaplain's Personal Freedom	Chpl.7: I just trained the three questions and the four layers.
	Effective Teaching Methods for the Introduction Phase	Chpl.8: It became clear that in any case we had to end on the three Mount Vernon questions. So I sort of wrote the training in that direction. In this way that was part of the preparation: this is it, folks. The session was supposed to take an hour and a half according to the study protocol, but this could be done in 45 minutes. We ended with what we then thought was the most practical tool: the three Mount Vernon questions.
	Effective Teaching Methods for the Expansion Phase	
	Effective teaching methods for the Rounding-Off Phase	Chpl.9: For instance, I worked, but in a very limited way, with Carlo Leget's model, the diamond; I also used Erhard Weiher's three-part

model, I especially focused on that.


Assessed for eligibility
n = 27 Teaching hospitals
Excluded (n = 20)
• Not responding (n = 16)
• Not meeting inclusion criteria (n = 2)
• Other reasons (n = 2)
Methodological objections (n = 1)
Chaplaincy team understaffed (n = 1)
8 Hospitals included in trial
8 Multidisciplinary teams
1 Monodisciplinary team
Healthcare professionals scheduled for training n = 374
T1 Pre intervention
Chaplains interviewed n = 9
Performed intervention: training spiritual care
T2 Post intervention
Evaluation training spiritual care
Chaplains interviewed n = 11